STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 www.state.ar.us/dfa/ebd

Change Form
Status, Name and Address

1. Employee Information: (please print)				
Last Name	First Name		MI	❒ Married ❒ Single
Home Address	City	State	Zip Code	
SSN#	Date of Birth:	Home #:	Work #:	
If you would like benefit information sent to you by email, please print your email address:				
Primary Care Physician:	PCP #	Current patient?		

2. Change in Dependent Status (complete this portion if making any changes in dependent status):			
FIRST NAME	LAST NAME	MI	GENDER
Social Security #	Date of Birth	❒ Add	❒ Delete
Primary Care Physician:	PCP #	Full time student?**	
FIRST NAME	LAST NAME	MI	GENDER
Social Security #	Date of Birth	❒ Add	❒ Delete
Primary Care Physician:	PCP #	Full time student?**	
FIRST NAME	LAST NAME	MI	GENDER
Social Security #	Date of Birth	❒ Add	❒ Delete
Primary Care Physician:	PCP #	Full time student?**	

*** Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.**
****For dependents 19 and over only. Please submit proof of student status.**

3. Change In Coverage (complete this portion if making any of the following changes):	
Change in Status:	Reason for Change:
❒ Employee Only ❒ Employee & Spouse ❒ Employee & Children ❒ Family ❒ Cancel Coverage ❒ Add Dependent ❒ Delete Dependent ❒ Name ❒ Address	❒ Birth - Date: _____ ❒ Death - Date: _____ ❒ Divorce - Date: _____ ❒ Marriage* - Date: _____ ❒ Other: _____

*** Please attach Marriage License; Maiden Name if applicable**

4. To Be Completed By Agency/School District:	
Agency/School District Name:	Agency/School District #:
Effective Date of Change:	Employee #:
Representative Signature:	Date:

Employee Signature: _____ **Date:** _____